641—201.6(135,75GA,ch158,78GA,ch41) Provider network and contracts; treatment and services.

201.6(1) Each ODS shall have flexibility in establishing a provider network to achieve the balance of providers which best meets the needs of its enrollees. An ODS may determine its own standards and criteria by which it determines which providers will be included in its network. These standards and criteria shall be public and the ODS shall be held accountable for abiding by the standards and criteria. An ODS shall establish an internal first level provider appeal process.

201.6(2) An ODS shall not use the design of its provider network as a means for discouraging enrollment from high-risk or special needs populations.

201.6(3) Each ODS shall provide data to the department on the utilization of all providers by its enrollees, by provider type. This information shall be disseminated as part of the ODS report card.

201.6(4) A list of available ODS providers, which shall be updated at least once a year, shall be provided to enrollees on request.

201.6(5) An ODS shall be encouraged to establish working relationships with essential community providers. The department shall provide for the identification of essential community providers within the service area of each ODS. The director shall establish criteria for essential community provider designation. The criteria shall focus on:

a. Whether the provider has a demonstrated record of service to impoverished or medically underserved populations which face language, ethnic, or cultural barriers to health care access or which have health care needs that are not being met by other providers in the geographic area; and

b. Whether the provider is an entity who serves all patients regardless of ability to pay and who charges for services on an income-based sliding fee schedule.

201.6(6) Emergency services. Emergency services, as defined in rule 201.2(135,75GA,ch158), shall be provided by the ODS, either through its own facilities or through guaranteed arrangements with other providers, on a 24-hour basis.

a. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services.

b. Since ODSs are not required to contract with every emergency care provider in an area, ODSs shall make every effort to inform enrollees of participating providers.

c. Reimbursement to a provider of emergency services shall not be denied by any ODS without review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided.

d. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. Coverage for emergency services is subject to the terms and conditions of the health plan or contract.

e. If reimbursement for emergency services is denied, the enrollee may file a complaint with the ODS as outlined in rule 201.7(135,75GA,ch158). Upon denial of reimbursement for emergency services, the ODS shall notify the enrollee and the provider that they may register a complaint with the department.

f. Prior authorization for emergency services shall not be required. All services necessary to evaluate and stabilize an emergency medical condition shall be considered covered emergency services.

201.6(7) All provider contracts shall contain the following provisions:

a. (Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to, nonpayment by the ODS, ODS insolvency or breach of this agreement, shall (provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the ODS acting on their behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental charges or copayments on an ODS's behalf made in accordance with the terms of (applicable agreement) between an ODS and subscriber/enrollee.

b. (Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the ODS subscriber/enrollee and that (2) this provision supersedes any oral or written

contrary agreement now existing or hereafter entered into between (provider) and subscriber/enrollee or persons acting on their behalf.

201.6(8) Prohibition of interference with medical communications.

a. An ODS shall not prohibit, penalize, or otherwise restrict a participating provider from advising an enrollee of the ODS about the health status of the enrollee or medical care or treatment of the enrollee's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the provider is acting within the lawful scope of practice.

b. An ODS shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the ODS that, in the opinion of the provider, jeopardizes patient health or welfare.

c. An ODS shall not prohibit, penalize, or otherwise restrict a provider from advocating on behalf of a covered individual within a review or grievance process established by the organized delivery system.

201.6(9) Continuity of care—pregnancy.

a. An ODS that terminates its contract with a participating health care provider shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

b. A covered person who makes an involuntary change in health plans may request that the new health plan cover the services of the covered person's physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Continuation of such coverage shall continue through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit level shall be according to the terms and conditions of the new health plan contract.

c. An ODS that terminates the contract of a participating health care provider for cause shall not be liable to pay for health care services provided by the health care provider to a covered person following the date of termination.

201.6(10) Continuity of care—terminal illness.

a. If an ODS terminates its contract with a participating health care provider, a covered individual who is undergoing a specified course of treatment for a terminal illness or a related condition, with the recommendation of the covered individual's treating physician licensed under Iowa Code chapter 148, 150, or 150A, may continue to receive coverage for treatment received from the covered individual's physician for the terminal illness or a related condition, for a period of up to 90 days. Payment for covered benefits and benefit level shall be according to the terms and conditions of the contract.

b. A covered person who makes a change in health plans involuntarily may request that the new health plan cover services of the covered person's treating physician licensed under Iowa Code chapter 148, 150, or 150A, who is not a participating health care provider under the new health plan, if the covered person is undergoing a specified course of treatment for a terminal illness or a related condition. Continuation of such coverage shall continue for up to 90 days. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

c. Notwithstanding paragraphs *"a"* and *"b"* above, an ODS that terminates the contract of a participating health care provider for cause shall not be required to cover health care services provided by the health care provider to a covered person following the date of termination.

201.6(11) Experimental treatment review. An ODS that limits coverage for experimental medical treatment, drugs, or devices, shall develop and implement a procedure to evaluate experimental medical treatments.

a. A description of the procedure must be submitted to the division of insurance in writing and include, at a minimum:

(1) The process used to determine whether the ODS will provide coverage for new medical technologies and new uses of existing technologies;

(2) A requirement for review of information from appropriate government regulatory agencies and published scientific literature concerning new medical technologies, new uses of existing technologies, and the use of external experts in making decisions; and

(3) A process for a person covered under a plan or contract to request an appeal of a denial of coverage because the proposed treatment is experimental.

b. An evaluation of a particular treatment shall not be required more than once a year.

c. An ODS shall include appropriately licensed or qualified professionals in the evaluation process.

d. An ODS that limits coverage for experimental treatment, drugs, or devices shall clearly disclose such limitations in a contract, policy, or certificate of coverage.

201.6(12) Utilization review requirements. An organized delivery system that provides health benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third party who does not meet the requirements established for accreditation by the Utilization Review Accreditation Commission, National Committee on Quality Assurance, or another national accreditation entity recognized and approved by the commissioner. This subrule does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under any of the following:

1. Title XVIII of the federal Social Security Act.
2. The civilian health and medical program of the uniformed services.
3. Any other federal employee health benefit plan.